GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please note: All information below is required to process this request.
Mon-Fri: 8am to 1am Eastern / Sat: 9am to 6pm Eastern

Atypical Antipsychotics Prior Authorization Request Form (Page 1 of 4)

Note: If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed.
Please complete one form per member.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Is this a tapering off dose for discontinuation? ❑ **Yes** ❑ **No**

Select the diagnosis below:

- ❑ Chronic Aggression
- ❑ Depressive Episodes of Bipolar Disorder (Bipolar Depression)
- ❑ Major Depressive Disorder (MDD)
- ❑ Major Depressive Disorder with Psychosis
- ❑ Manic or Mixed Episodes of Bipolar Disorder
- ❑ Oppositional Defiant Disorder
- ❑ Pervasive Developmental Disorder (PDD)/Autism/Irritability associated with Autism/PDD
- ❑ Schizophrenia/Schizoaffective Disorder
- ❑ Suicidal Behavior associated with Schizophrenia/Schizoaffective Disorder
- ❑ Tics
- ❑ Tourette's Disorder
- ❑ Treatment-Resistant Major Depressive Disorder (MDD)
- ❑ Treatment-Resistant Schizophrenia/Schizoaffective Disorder
- ❑ Other (specify): _____

Answer the following:

Is the member being referred to a psychiatrist and awaiting an appointment? ❑ **Yes** ❑ **No**

Date of appointment: _____ Psychiatrist: _____

What is the member's age in years? ❑ ≥18 ❑ 10-17 ❑ 6-9 ❑ 5 ❑<5

Is there a monitoring plan/will the member be monitored for evaluating safety and effectiveness of the medication?

❑ **Yes** ❑ **No**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Atypical Antipsychotics Prior Authorization Request Form (Page 2 of 4)

If the member is younger than FDA-approved age for medication(s) requested, please complete section E (page 4)

Medication Generic Name (Brand Name)	Under FDA-Approved Age
Aripiprazole oral solution and oral disintegrating tablets (Abilify/Abilify Discmelt)	<6 years of age for autism/PDD or Tourette's; <10 years of age for bipolar; <13 years of age for schizophrenia; <18 years of age for MDD
Aripiprazole tablets (Abilify)	<6 years of age for autism/PDD or Tourette's; <10 years of age for other diagnoses
Aripiprazole long-acting injection (Abilify Maintena, Abilify MyCite, Aristada, Aristada Initio)	<18 years of age
Asenapine sublingual tablets (Saphris)	<10 years of age for bipolar; <18 years of age for schizophrenia
Asenapine transdermal patch (Secuado)	<18 years of age
Brexpiprazole (Rexulti)	<18 years of age
Cariprazine (Vraylar)	<18 years of age
Clozapine (Clozaril, FazaClo, Versacloz)	<18 years of age
Iloperidone (Fanapt)	<18 years of age
Lumateperone (Caplyta)	<18 years of age
Lurasidone (Latuda)	<10 years of age for bipolar depression; <13 years of age for schizophrenia
Olanzapine/fluoxetine (Symbyax)	<18 years of age for treatment-resistant MDD; <10 years of age for bipolar depression
Olanzapine (Zyprexa/Zyprexa Zydis)	<10 years of age for bipolar depression; <13 years of age for other diagnoses
Olanzapine long-acting injection (Zyprexa Relprevv)	<18 years of age
Paliperidone (Invega)	<12 years of age
Paliperidone long-acting injection (Invega Sustenna/Trinza)	<18 years of age
Quetiapine immediate-release (Seroquel)	<10 years of age
Quetiapine extended-release (Seroquel XR)	<10 years of age
Risperidone (Risperdal/Risperdal M-Tab)	<5 years of age for autism/PDD; <10 years of age for other diagnoses
Risperidone extended-release injection (Perseris)	<18 years of age
Risperidone long-acting injection (Risperdal Consta)	<18 years of age
Ziprasidone (Geodon)	<18 years of age

NOTE: Section A or B MUST be completed below.

❑ **SECTION A: <u>The member has been established on the requested medication</u>**

How long has the member been taking the requested medication? ❑ **< 2 weeks** ❑ **≥ 2 weeks**

Has the member shown improvement in symptoms while on the requested medication? ❑ **Yes** ❑ **No**

If **yes**, please check one or more boxes below for areas of improvement:

❑ Blunted affect
❑ Conceptual disorganization
❑ Delusions
❑ Depressive symptoms
❑ Difficulty in abstract thinking
❑ Emotional withdrawal
❑ Excitement
❑ Grandiosity
❑ Hallucinatory behavior
❑ Hostility
❑ Lack of spontaneity and flow of conversation
❑ Passive/apathetic social withdrawal
❑ Poor rapport
❑ Stereotyped thinking
❑ Suicidal thoughts
❑ Suspiciousness/persecution
❑ Other: _____

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Atypical Antipsychotics Prior Authorization Request Form (Page 3 of 4)

❑ **SECTION B: <u>The member has never taken the requested medication</u>**

Which of the following preferred medications has the member tried? (check all that apply)

❑ Aripiprazole **Dates**: _____ ❑ Ziprasidone **Dates**: _____ ❑ Olanzapine **Dates**: _____

❑ Risperidone **Dates**: _____ ❑ Quetiapine IR/ER **Dates**: _____ ❑ None

Reason the following preferred medications are not appropriate for the member. (complete for each applicable drug in the following table)

Drug	Reason inappropriate choice for member
Aripiprazole	
Latuda	
Olanzapine	
Risperidone	
Quetiapine IR/ER	
Ziprasidone	

For aripiprazole, Rexulti, quetiapine extended-release and olanzapine-fluoxetine for major depressive disorder only: Reason antidepressant monotherapy is not adequate for the member. (complete for each drug/class)

Drug	List medication name, response, and dates of therapy
SNRIs (desvenlafaxine [Pristiq], duloxetine [Cymbalta], venlafaxine [Effexor/XR])	
SSRIs (citalopram [Celexa], escitalopram [Lexapro], fluvoxamine [Luvox], fluoxetine [Prozac], paroxetine [Paxil], or sertraline [Zoloft])	
Other Antidepressants (bupropion, mirtazapine, trazodone, vortioxetine; list may not be all inclusive)	

❑ **SECTION C. If an orally disintegrating tablet, oral solution or transdermal patch is being requested, also answer the following:**

What prevents the member from taking a solid oral dosage formulation? (check all that apply)

❑ Dysphagia ❑ Compliance monitoring required ❑ Dose cannot be obtained from solid oral dosage form

❑ Other (specify): _____

❑ **SECTION D. If Abilify Maintena, Aristada/Aristada Initio, Invega Sustenna, Invega Trinza, Perseris, Risperdal Consta or Zyprexa Relprevv is being requested, also answer the following**

Has the member tried oral aripiprazole (if Abilify Maintena or Aristada/Aristada Initio is being requested), oral risperidone or oral paliperidone (if Risperdal Consta or Invega Sustenna is being requested), oral risperidone or oral paliperidone and Risperdal Consta (if Perseris) is being requested, Invega Sustenna (if Invega Trinza is being requested) or oral olanzapine (if Zyprexa Relprevv is being requested) or does the member have a history of noncompliance with oral medications and is unable to receive a trial of the appropriate oral atypical antipsychotic before starting long-acting therapy with injection or is the member unable to swallow or use orally disintegrating tablets? ❑ **Yes** Date of last therapy: _____ ❑ **No**

Is the prescribing physician a psychiatrist or has a psychiatrist been consulted? ❑ **Yes** ❑ **No**

Where will the medication be administered?

❑ Home or other outpatient pharmacy setting by a trained health care professional
❑ Long-term care facility
❑ CSB (Community Service Board)
❑ Physician office or clinic**
❑ Other (specify): _____

** If you are requesting for authorization for administration in a physician's office or clinic other than a CSB, please go to the Registered User portion of the Georgia Health Partnership website at https://www.mmis.georgia.gov/portal to request a PA from Physician Services.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Atypical Antipsychotics Prior Authorization Request Form (Page 4 of 4)

SECTION E: In the space below, please provide letter of medical necessity and any additional information you deem clinically relevant in evaluating the prior authorization request:

Physician signature: _____

Contact person: _____ **Phone:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-888-491-9742.